

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043410

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 116

Primary Registration District No. 5425

Registrar's No. 252

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED NOV 26 1963

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BOEUF		c. CITY OR TOWN Berger, Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION His Home		d. STREET ADDRESS (If outside, give location) 1/4 M West of Berger, Mo	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD PETER JOHN FINKE		4. DATE OF DEATH Month Day Year Nov 16 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11a. FATHER'S NAME Henry Finke		11b. MOTHER'S MAIDEN NAME Mary Schneider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 4 YRS		12. CITIZEN OF WHAT COUNTRY USA	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 1955 to 11-16-63 and last saw her alive on 11-9-63 Death occurred at 2:30PM on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) George M. Workman M.D.	
22b. ADDRESS HERMANN, Mo		22c. DATE SIGNED 11-18-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-18-1963	23c. NAME OF CEMETERY OR CREMATORY St. John's E&R Cem.	23d. LOCATION (City, town, or county) (State) Berger Mo.
24. FUNERAL DIRECTOR Pamett Blumer	25. DATE REC'D BY LOCAL REG. 11/20/63	26. REGISTRAR'S SIGNATURE Leola C. Hickmann	

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OFVS 300
Rev. 4/59

1 0360

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DEC 2 1963

JAN 17 1964

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oswald L. Grover

Licensed Embalmer No. 5187

P. O. Address German, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.